Term Life Insurance Complete this form to enroll. THIS IS NOT AN APPLICATION FOR INSURANCE: This is an enrollment form.

If you already have Unum coverage: Please be aware that any new benefit elections on this form will replace all existing elections. If you do not wish to make changes, you do not need to complete this form. Please contact your plan administrator for assistance.

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Step 1: Complete your personal	information					
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rust name (please print)		M. IIIIIdi La	st name			0281
Social Security Number	Gender Date of	birth (mm-dd-yyyy)				
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Street address					Aparti	ment #
City		, f	State	ZIP code		
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Original hire date An	nual salary	Occupation		Li		ours worked
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Did you recently become eligible for benefits?	Have you beer by your compa	rehired (Y/N)	If so, plea a date (m	ise provide im-dd-yyyy)		
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Spouse first name (please print)		M. initial Las	st name			
Date of birth (mm/dd/yyyy)						
Step 2: Choose a coverage amou	int (you may use ti	ne worksheet to c	alculate your co	351)		
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Want a different amount? < □ \$

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## Step 3: Name your beneficiaries

**Your primary beneficiary** is the person (or persons) who will receive the benefit payment from your life insurance policy if you were to die. **The total percent of benefit** must not exceed 100%.

First name (please print)	M. initial	Last name		Relationship (parent, child, friend, etc.)	% of benefi
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First name (please print)	M. initial	Last name		Relationship (parent, child, friend, etc.)	% of benefi
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First name (please print)	M. initial	Last name		Relationship (parent, child, friend, etc.)	% of benefi
Your secondary beneficiary would receive	e the benefi	t payment froi	m your life insurance policy	/ if a primary beneficiary is no longo	er living.
First name (please print)	M. initial	Last name		Relationship (parent, child, friend, etc.)	% of benefit
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First name (please print)	M. initial	Last name	The second secon	Relationship (parent, child, friend, etc.)	% of benefit
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I have read and understand the "Exclusion listed on the Benefit Brochure. All statem best of my knowledge and belief. I under of this form will be made available to me authorize my employer to make the necest my salary or wages to pay the premium becomes effective. I understand that my amount will change if my coverage or comade an error completing this form.	nents are true erstand that a e at my reque essary deduct when my ins payroll dedu	e to the copy est. I tions from surance ection	No, I do not want Dismemberment  I understand that if I e complete evidence of	t coverage under the Term Life Insura coverage under Accidental Death & lect coverage in the future, I may nee insurability relative to my health state ermine my eligibility for coverage.	ed to
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Signature Date			Signature	Date	
			Return forms to: plan a	dministrator	
Delayed effective date of coverage Insurance coverage will be delayed if you are not an active Insurance coverage will be delayed if you are not an active Insurance coverage will be delayed if your spouse or child has a seriou Insurance overage. Please refer to your policy contract or see your p	ıs iniurv, sicknes:	s, or disorder, or is	confined, their coverage may not ta	ske effect. Payment of premium does not quara	antee

Underwritten by: Unum Life Insurance Company of America, Portland, Maine

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